

Role of the Department of Insurance

**Prompt pay reporting and the “clean
claim” complaint process for
Medicaid Managed Care Organizations**

KRS 304.99-123 –

Penalties for noncompliance with KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135 and 304.99-123

- Allows the Department of Insurance to issue fines of up to \$1,000 per day or 10 percent of the unpaid claim (whichever is greater) if an insurer fails to pay, deny or contest:
 - At least 95 percent of the clean claims received during a calendar quarter; or
 - At least 90 percent of the total dollar amount of the clean claims received by an insurer during a calendar quarter.
- A separate fine of up to \$10,000 may be levied for willful and knowing violations or if an insurer has a pattern of repeated violations.

KRS 304.17A-702 –

Claims payment timeframes – Duties of insurer

- Requires “clean” claims to be paid, contested or denied within 30 days of receipt.

Note: A “clean” claim is a properly completed billing instrument – paper or electronic – including the required health claim attachments and submitted in the form outlined in statute.

KRS 304.17A-700

“Clean Claim”

means a properly completed billing instrument, paper or electronic, including the required health claim attachments, submitted in the following applicable form:

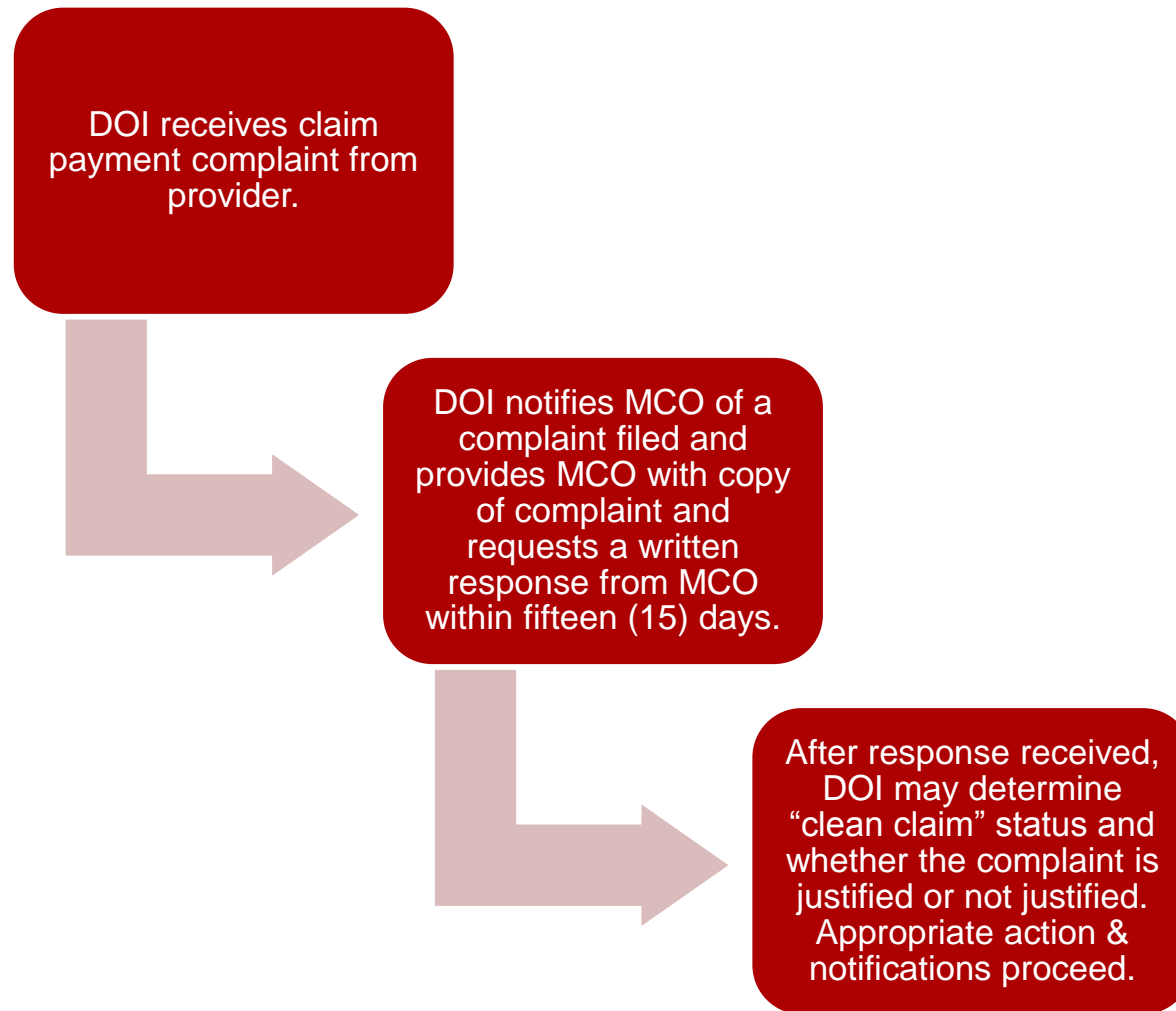
- (a) A clean claim from an institutional provider shall consist of:
 - 1. The UB-92 data set or its successor submitted on the designated paper or electronic format as adopted by the NUBC;
 - 2. Entries stated as mandatory by the NUBC; and
 - 3. Any state-designated data requirements determined and approved by the Kentucky State Uniform Billing Committee and included in the UB-92 billing manual effective at the time of service.
- (b) A clean claim for dentists shall consist of the form and data set approved by the American Dental Association.
- (c) A clean claim for all other providers shall consist of the HCFA 1500 data set or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Claims Committee.
- (d) A clean claim for pharmacists shall consist of a universal claim form and data set approved by the National Council on Prescription Drug Programs;

KRS 304.17A-730 –

Payment of interest for failing to pay, denying or settling a clean claim as required

- Requires insurers to pay interest at the applicable rate for failure to pay, deny or settle a claim within the 30-day period established in KRS 304.17A-702.
 - This interest attaches as a matter of law.

Complaint Process



Submitting a prompt payment complaint

➤ DOI website <http://insurance.ky.gov>

✓ ***File a Complaint***

✓ ***How to File a Medicaid Prompt Payment Complaint***

❖ Paper

- *Kentucky Department of Insurance Medicaid Prompt Payment Complaint Form* and submit all supporting documentation

❖ Electronic

- DOI website allows electronic submission
 - Go to Tab— ***File a Complaint —Clean Claim Electronic Submission*** — the next step requires you to set up an E-Services Account—step by step instructions with graphics are provided in establishing an E-Services account.

What does DOI need to efficiently & effectively process your complaint?

- Providers
 - Completed clean claim complaint form
 - Claims specifically identified with a easily identifiable marking where DOI knows which services are being questioned
 - Copy of front and back of Member's ID card or copy from the MCOs' database confirming Member's status
 - Detailed explanation of complaint—for each services complaint is being filed for
 - What services are being complained about?
 - When was it originally submitted for payment?
 - Was it denied? Was it protested? Was it returned for more information?
 - How many times was it submitted and when?
 - Copy of pre-authorization if applicable
 - Has MCO provided a copy of all services requiring pre-authorizations?
 - Timelines with dates and copies of correspondence

KENTUCKY DEPARTMENT OF INSURANCE
MEDICAID PROMPT PAYMENT COMPLAINT FORM

*Please remember, without proper documentation,
your complaint cannot be processed!
Use this form or set up an eServices account to
submit online.
Questions: Call 800-595-6053 (toll free in KY) or
502-564-6034*

Mail this completed form and all supporting documentation to:
Medicaid Prompt Payment Compliance Branch
Kentucky Department of Insurance
P.O. Box 517
Frankfort, KY 40602-0517
Or fax it to 502-564-6090

Provider Name: _____ **NPI #:** _____

Provider Type (e.g., pharmacist, physician, etc.): _____

Address: _____ **City:** _____ **State:** ____ **ZIP:** _____

Contact Person Name (printed): _____
(First) _____ (Last)

Phone: () _____ **Fax:** () _____ **Email:** _____

On behalf of the provider, I certify that the information included is correct:

Signature: _____ **Title:** _____ **Date:** _____

Managed Care Organization (MCO) Name: _____

Member Name: _____ **KY Medicaid Member ID #:** _____

DESCRIPTION OF CLAIM AND VERIFICATION OF UNTIMELY PAYMENT

(See next page to file for additional dates of service)

Reason(s) for complaint: ☐ Delays ☐ Denials ☐ Authorization ☐ Recoupment
☐ Medical Necessity ☐ Claim recoding/bundling ☐ Interest only
☐ Unsatisfactory settlement/offer ☐ Other:

Date services rendered: _____ Amount of original claim: \$ _____

Date claim first sent to MCO: _____ Sent by: ☐ Mail ☐ Electronic
(Attach copy of original claim (UP-92, EOP, HCFA-1500, etc.) with any attachments sent)

Are you a participating provider with the MCO? ☐ Yes ☐ No

Has the MCO acknowledged receipt of the claim? ☐ Yes ☐ No If yes, when? _____ (Attach copy)

Has the MCO denied receipt of the claim? ☐ Yes ☐ No (If yes, attach any documented written proof of your transmittal)

Has the MCO denied/contested the claim in writing? ☐ Yes ☐ No (If yes, attach copy)

Please specify code(s) denied and reason(s) for denial. (Please attach on separate sheet)

Has the MCO made any payment? ☐ Yes ☐ No If yes, how much? \$ _____, and when?

Has the MCO requested additional information? ☐ Yes ☐ No If yes, what information was provided by you to the MCO and when was it provided?

(Attach copy)

Medicaid Prompt Payment Complaint Form--Additional Dates of Service

Feel free to make copies of this page if you have additional dates of service.

Provider Name & NPI #: _____

KY Medicaid Member Name & ID: _____

Managed Care Organization (MCO) Name: _____

Reason(s) for complaint: ☐ Delays ☐ Denials ☐ Authorization ☐ Recoupment
☐ Medical Necessity ☐ Claim recoding/bundling ☐ Interest only
☐ Unsatisfactory settlement/offer ☐ Other: _____

Date services rendered: _____ Amount of original claim: \$ _____

Date claim first sent to MCO: _____ Sent by: ☐ Mail ☐ Electronic
(Attach copy of original claim (UP-92, EOP, HCFA-1500, etc.) with any attachments sent)

Are you a participating provider with the MCO? ☐ Yes ☐ No

Has the MCO acknowledged receipt of the claim? ☐ Yes ☐ No If yes, when? _____ *(Attach copy)*

Has the MCO denied receipt of the claim? ☐ Yes ☐ No *(If yes, attach any documented written proof of your transmittal)*

Has the MCO denied/contested the claim in writing? ☐ Yes ☐ No *(If yes, attach copy)*

Please specify code(s) denied and reason(s) for denial. *(Please attach on separate sheet)*

Has the MCO made any payment? ☐ Yes ☐ No If yes, how much? \$ _____, and when? _____

Has the MCO requested additional information? ☐ Yes ☐ No If yes, what information was provided by you to the MCO and when was it provided? _____

(Attach copy)

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☐ Medical Necessity ☐ Claim recoding/bundling ☐ Interest only
☐ Unsatisfactory settlement/offer ☐ Other: _____

Date services rendered: _____ Amount of original claim: \$ _____

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Are you a participating provider with the MCO? ☐ Yes ☐ No

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Has the MCO denied receipt of the claim? ☐ Yes ☐ No *(If yes, attach any documented written proof of your transmittal)*

Has the MCO denied/contested the claim in writing? ☐ Yes ☐ No *(If yes, attach copy)*

Please specify code(s) denied and reason(s) for denial. *(Please attach on separate sheet)*

Has the MCO made any payment? ☐ Yes ☐ No If yes, how much? \$ _____, and when? _____

Has the MCO requested additional information? ☐ Yes ☐ No If yes, what information was provided by you to the MCO and when was it provided? _____

(Attach copy)

[illegible]

cant read this.

What does DOI need to efficiently & effectively process your complaint?

❖ Managed Care Organizations—MCOs

- Acknowledgement of receipt of e-mails sent by DOI—either by automatic or manual
- More details in your explanation answering the complaint—be more specific
- Request extensions of time in writing and be precise with amount of time needed to complete requests—all extensions will be on a case by case basis and monitored

DOI Medicaid Prompt Payment Compliance Branch Process

- Receive the complaint, review for attached documentation
- Enter the complaint by the individual member's name and assign a case number
 - Review the documentation to identify the number of claim lines associated with the individual member and identify which claims are in need of review.
 - Determine if additional information is needed from complaint and request if appropriate

DOI Medicaid Prompt Payment Compliance Branch Process

- Notify the MCO in writing that a complaint has been received and provide a copy of the complaint to the MCO
 - The MCO is required to respond in writing to DOI within 15 days
- Upon receipt of the MCO's response, DOI will review and request additional information if necessary
 - DOI will make determination:
 - Clean Claim
 - Justified
 - Not Justified

DOI Medicaid Prompt Payment Compliance Branch Process

- Notify the Provider and MCO of the determination
- If MCO is responsible for paying the claim, the claim is required to be paid within 30 days with interest if applicable
- MCO provides to DOI verification of payment at time of payment
- If either party disagrees with DOI determination, there are appeals processes which follow the Department of Medicaid Services appeals and hearings processes.

Thank you

The Department of Insurance appreciates the cooperation of the Healthcare Service Providers, the Medicaid Managed Care Organizations and the Department for Medicaid Services as we collectively and cooperatively work to manage and improve the payment of claims and the delivery of healthcare for our citizens in the Commonwealth.

Please feel free to contact us if you have any questions.

<http://insurance.ky.gov>

800-595-6053 or 502-564-6034